STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Applewood Estates	One Applewood Drive Freehold, NJ 07728

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44833 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain proper infection control practices by; a) performing hand hygiene during medication administration and b) donning (putting on) the appropriate Personal Protective Equipment (PPE) prior to entering an Enhanced Barrier Precaution room. This deficient practice was identified for 1 of 6 residents observed during medication administration (Resident #20) and 1 of 3 residents observed for wound care (Resident #28), and was evidenced by the following: 1. On 11/24/24 at 9:45 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) conduct medication administration. After administering medications to Resident #26, LPN #1, without performing hand hygiene and still holding the cup of water which Resident #26 used to drink from, went directly over to Resident #20. LPN #1 proceeded to adjust Resident #20's blanket and brushed her hand overtop the resident's hair while informing Resident #20 that she would administer their medications. LPN #1 then proceeded back to the medication cart, located in the hallway outside the resident's door, and disposed of Resident #26's used cup of water. LPN #1, without performing hand hygiene, documented in the computer on of the medication cart; then accessed the medication cart drawer to obtain Resident #20's assistive hearing devices. LPN #1, still with no performed hand hygiene, obtained the blood pressure machine and proceeded to Resident #20's bedside where she donned disposable gloves and placed the resident's assistive hearing devices on the resident. LPN #1 then doffed (took off) her gloves and without performing hand hygiene, placed the blood pressure cuff on the resident to obtain the resident's vital signs. LPN #1 then removed the blood pressure cuff off the resident's arm and brought the machine back out to the hallway. Without performing hand hygiene, LPN #1 then donned clean gloves and disinfected the machine using disinfecting wipes. LPN #1 then disposed of the wipe, doffed and disposed the gloves and then performed hand hygiene with alcohol-based hand rub (ABHR). On 11/24/24 at 10:05 AM, the surveyor interviewed LPN #1 who confirmed that she forgot to perform hand hygiene in between residents during medication administration and that it was important for infection control purposes. On 11/26/24 at 10:02 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN), who stated that the general expectation was to perform hand hygiene with soap and water or use ABHR before starting a procedure and in between residents. The IP/RN further stated that hand hygiene was to be performed in between glove changes always. The IP/RN confirmed LPN #1 should have performed hand hygiene after administering Resident #26's medications before touching Resident #20; prior to accessing the medication cart; and prior to donning and after doffing gloves. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 9:41 AM, the Director of Nursing (DON), in the presence of the survey team, the [NAME] President of Clinical Operations (VPCO), the Licensed Nursing Home Administrator (LNHA), and the Director of Clinical Operations (DCO), acknowledged that proper hand hygiene was to be performed by all nurses while administering medications. 2. On 11/24/24 at 11:32 AM, the surveyor reviewed Resident #28's electronic medical record which indicated the following: A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis which included but was not limited to; infection of the skin and subcutaneous tissue (layer underneath the skin) and pressure ulcer of the sacral region (lower back). A review the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 10/16/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated a fully intact cognition. A further review in Section M Skin Conditions indicated the resident had one stage 4 (full tissue thickness) pressure ulcer. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 10/11/24, for risk for impaired skin integrity and updated 10/11/24, to include a sacral pressure ulcer dated 11/20/24. Interventions included to provide treatment to sacral pressure ulcer as ordered and monitor for effectiveness. A review of the November 2024 Treatment Administration Record (TAR) included a physician's order dated 11/21/24, to cleanse sacral wound with normal saline solution (NSS)and apply Polymed non-adhesive pad (gauze pad and dressings) every day shift for wound care. If dressing loosens, apply Tegaderm (clear adhesive bandage). On 11/26/24 at 12:24 PM, the surveyor observed LPN #2 and LPN #3 perform wound care for Resident #28. On the resident's room door was a sign which indicated Enhanced Barrier Precautions (EBP) that required everyone to wear PPE which included gloves and a gown for the following high-contact resident care activities which included wound care. The surveyor observed a PPE bin outside the resident's door which contained gloves and gowns. The surveyor observed LPN #2 and LPN #3 preparing and gathering supplies for wound care; donned gloves prior to entering the resident's room, but did not don a gown. LPN #2 and LPN #3 then performed wound treatment on Resident #28 without wearing a gown. On 11/26/24 at 1:04 PM, LPN #2 and LPN #3 completed wound care and exited the resident's room. At that time, the surveyor interviewed both LPNs, who confirmed that a gown was required as part of the PPE needed to be worn during wound care and confirmed that the EBP sign on the resident's door indicated that as well. LPN #2 and LPN #3 both acknowledged that they forgot to put on a gown as required prior to and during the wound care treatment procedure. On 11/26/24 at 1:46 PM, the surveyor interviewed the DON, who confirmed Resident #28 had a sacral wound and that wound care would be classified as close contact care and required the person providing the care to wear a gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 9:41 AM, the DON, in the presence of the survey team, the VPCO, the LNHA, and the DCO, acknowledged that the LPNs should have worn a gown during wound care since the resident was on EBP. A review of the facility's Infection Control General Guidelines for All Nursing Procedures policy revised September 2019, included; .4. in most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. before and after direct contact with residents; b. before donning sterile gloves; c. before performing any non-surgical invasive procedures; d. before preparing or handling medications; e. before handling clean or soiled dressings, gauze pads, etc.; f. before moving from a contaminated body site to a clean body site during resident care; g. after contact with a resident's intact skin; h. after handling used dressings, contaminated equipment, etc.; i. after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and j. after removing gloves; 5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials; 6. In addition to these general guidelines, refer to procedures for any specific infection control precautions that may be warranted . A review of the facility's Enhanced Barrier Precautions policy revised 3/25/24, included; .Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug resistant organisms) to staff hands and clothing. The policy further included, for residents for whom EBP are indicted, EBP is employed when performing the following high contact resident care activities: .wound care: any skin opening requiring a dressing . NJAC 8:39 - 19.4(a); 27.1(a)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48782 Based on observations and interviews on 11/25/24, in the presence of the Director of Plant Operations (DOPO), it was determined that the facility failed to ensure that the resident call bell system properly functioned by a.) ensuring the call bell system volume was set to a level to be heard and b.) devices used to identify call bell notifications were functioning properly. This deficient practice had the potential to affect all residents and was evidenced by the following: On 11/25/24 at 1:08 PM, the surveyor observed when the call bell was tested for Resident room [ROOM NUMBER], there was no audible notification of the call. There was visual notification on the computer screen at the nurse's station and by light outside of the resident room. At the time of the observation, the surveyor interviewed the DOPO, who confirmed that there was no audible notification and stated that there should have been audible notification at the nurse's station. The DOPO stated that the aides also carried pagers that identified when a call bell had been activated. The DOPO then approached the nurse on duty and asked if they had a pager for the call bell system. The nurse stated that they did and proceeded to check their pockets. The nurse was unable to locate the pager in their pocket but was able to find it locked in the top drawer of the medication cart. The DOPO retrieved the pager to show the surveyor that the pager received notifications from the call bell system. The DOPO was unable to show that the pager received notifications from the call bell that was tested and stated that the pager was on vibrate mode. The DOPO was unsure of why the pager was not receiving notifications. On 11/25/24 at 1:24 PM, the surveyor observed when the call bell was tested for Resident room [ROOM NUMBER], there was no audible notification of the call bell system. The DOPO, while carrying the call bell pager, confirmed that they did not receive notification on the pager of the call bell activation. On 11/25/24 at 1:31 PM, the surveyor observed when the call bell was tested for Resident room [ROOM NUMBER], there was no audible notification of the call bell system. However, the aide on that unit received notification by pager of the call bell activation. On 11/25/24 at 2:00 PM, the surveyor interviewed the DOPO, who stated that they were able to figure out the problem with the audible notification at the nurse's station; that the volume had been turned down at the main computer. The DOPO stated he turned the volume up so that it could be heard. NJAC 8:39-31.2(e), 31.8(c)9